

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010922

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1167

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED MAR 19 1962

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>25 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>2545 Cherry</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>OTIS</u> Middle <u>ESCHBAUGH</u> Last <u>ESCHBAUGH</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner &amp; Opr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Silver Clean Polish Co.</u>	9. AGE (last birthday) <u>76</u>
11a. FATHER'S NAME <u>Rufus Eschbaugh</u>		11b. MOTHER'S MAIDEN NAME <u>Eleanor Ann Wickoff</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Rufus Eschbaugh</u>		13b. MOTHER'S MAIDEN NAME <u>Eleanor Ann Wickoff</u>	14. NAME OF HUSBAND OR WIFE <u>Lucille Eschbaugh</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>6</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>7</u> a.m. <u>7</u> p.m.	Month, Day, Year <u>1952</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Kansas City, Missouri</u>	
21. I attended the deceased from <u>1952</u> to <u>Feb 26 1962</u> and last saw him alive on <u>Feb 26 1962</u>		22. ADDRESS <u>1722 W 39th St. Mo</u>	
22a. SIGNATURE <u>M F Sewell M.D.</u>		22c. DATE SIGNED <u>2-27-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 1, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar</u>		25. DATE RECD. BY LOCAL REG. <u>2-27-62</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF

Thurs. 1:00 to 3:30

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

working under my personal supervision.

Student

**Signature of Student Embalmer**

**Signed**

Licensed Embalmer No

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.